

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 8 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Pemiscott
(b) City or town Wardell, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)
In this community 10 yrs. years, months or days

3. (a) PRINT FULL NAME William James Wheeler

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Male 5. Color of White 6. (a) Single, widowed, married, divorced. 9
6. (b) Name of husband or wife 6. (c) Age of husband or wife if

7. Birth date of deceased March 13, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 1 25 hr. min.

9. Birthplace Latimer Rock, Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name William Wheeler

13. Birthplace London, England
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Harris

15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Wheeler

(b) Address Reed, Dickson, Ark. Mo.

17. (a) Burial (b) Date thereof 5/10/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friendship Ark

18. (a) Signature of funeral director Wheeler

(b) Address Reed, Dickson, Ark.

19. (a) 5-10-1944 (b) Wheeler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pemiscott
(c) City or town Wardell, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1944 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from March 15, 1944 to May 8, 1944
that I last saw him alive on May 17, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death.

Cardio-respiratory failure 3 days

Due to Generalized Arteriosclerosis 10 yrs.

Due to Excessive use of tobacco all his life

Other conditions none

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature R. O. Conrad, M.D. (M. D. or other) M.D.

Address Portageville, Mo. Date signed 5-8-44

5-44-107

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

John R. Casner
Licensed Embalmer No. *2912*

P. O. Address

Rector, Ark

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.